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Set	Items	Description
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6/9/1 (Item 1 from file: 9)
 DIALOG(R)File 9: Business & Industry(R)
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02309417 Supplier Number: 25898506 **(THIS IS THE FULLTEXT)**
Promises and Pitfalls in Public Health Strategy for Suicide Prevention
(The US suicide rate is about 18.6 per 100,000 people; the US government provided \$75 mil for
youth suicide prevention through the Children's Health Act of 2000 and the reauthorization of the
Substance Abuse and Mental Health Services Administration)

Medicine & Health , v 54 , n 44 , p S1+
 November 13, 2000
Document Type: Newsletter **ISSN:** 1047-8892 (United States)
Language: English **Record Type:** Fulltext
Word Count: 3514

TEXT:

This is the second of two articles on the developing national strategy to prevent suicide. The first was published Nov. 6.

Bringing down suicide rates will be a major long-term test for a public health system that has increasingly branched out to address challenging issues such as chronic disease, despite financing that's lagged far behind the resources devoted to individual health care. Nevertheless, suicide, with its intermingled physical, psychological, and sociocultural facets may be the toughest test of all.

U.S. Surgeon General David Satcher, MD, is developing a national public-private strategy to lower suicide rates. Four steps are integral to the public health process, according to Satcher: defining the problem, identifying causes and protective factors, developing and testing interventions, and implementing interventions.

In general, the multiple "causes" of suicide are well known. However, when the question turns to producing a list of risk factors and protections that will aid prevention, the picture gets murkier.

"The clinical assessment of patients who are at high risk for committing suicide or making a serious suicide attempt has proven to be

disappointingly imprecise," according to Columbia University researcher J. John Mann, MD, who chairs the scientific council of the American Foundation for Suicide Prevention (AFSP). "Traditional suicide risk factors -- past history of a suicide attempt, male gender, living alone, suffering from a psychiatric disorder, having a formed plan for suicide, making preparations for the suicide attempt, disposing of valued personal possessions, preparing a will -- are often found in cases of suicide. Unfortunately these risk factors are also found in high rates among psychiatric patients who never attempt suicide."

One avenue to pursue: biomedical research that could reveal biological markers. As a result of such research, over the past two decades, "a large range of biochemical abnormalities" have been found that "distinguish the brains of suicide victims," notably abnormally low levels of the chemical transmitter serotonin and its metabolites, says Mann. Genetic suicide links are also being sought. For example, a decade-long AFSP-sponsored study by Raymond DePaulo, MD, of the Johns Hopkins School of Medicine is investigating whether differing genetic profiles of two families with inherited bipolar illness may account for the fact that one family has a 600 percent higher rate of suicide.

Discovering short-term rather than long-term risk factors could yield useful causal data. However, while long-term factors can be determined from examining people's lifetime medical and personal histories, the factors that lead to imminent suicide are much harder to ferret out.

Nevertheless, practical information on short-term risk did turn up in a study of depression conducted by researchers at Washington University in St. Louis. The study enrolled 954 patients with unipolar and bipolar depression, of whom eight committed suicide during the first six months, and 32 completed suicides over the course of the study. To their surprise, researchers found that, overall, "very few of the traditional suicide predictors held up" under analysis, according to lead scientist Jan Fawcett, MD. Eventually, "We realized that suicidal ideation, prior suicide attempts, and all of the traditional predictors predict the long-term risk...not the short-term risk." Short-term risk is of great practical importance to clinicians.

The major predictor that emerged was an unexpected one, says Fawcett: Anxiety symptoms could predict 93 percent of the 14 suicides that occurred during the first year of the study, though they did not predict later suicides. "A high level of anxiety was the most important short-term predictor...and perhaps the most treatable one." Heretofore overlooked as a significant stressor in at-risk patients, anxiety may in fact constitute "a recent development that makes life intolerable for patients if they can see no alternative or escape," Fawcett says.

Data from Australia's now five-year-old effort to prevent suicides among young people have "underscored the importance of interventions that address protective factors as well as risk factors," according to the Australian Institute for Family Studies (AIFS). Developing such interventions won't be easy, however, since such protective factors "clearly remain a poorly understood and untapped resource."

The very large differences in suicide rates among demographic groups make clear that protective factors do operate. For example, nonwhite women in the United States have had strikingly low rates of suicide for as long as records have been kept, although they have roughly the same rates of major mental illness as other groups.

Seeking out such factors is a further complication for the public health

effort for several reasons. Social and cultural risk factors are less amenable to controlled scientific studies than are the conditions that indicate an individual's suicide risk. Furthermore, decreasing or increasing such factors falls outside the traditional realm of medical practice, calling for community-wide efforts that go far beyond strategies society has used to control infectious diseases.

Isolation a Common Factor

Among the slippery concepts that may contribute to suicide risk, one turns up as a likely candidate among many at-risk groups: isolation, broadly defined to include both geographical isolation and more subjective feelings of separation.

For example, in New Zealand, where suicide rates are particularly high among indigenous Maori young people, a government research review notes that Maori youth generally experience about the same levels of other risk factors -- such as family breakdown, social disadvantage, drug and alcohol abuse, and mental illness -- as the rest of the population. For that reason, the high suicide rate is "thought to be related to the outcomes of trying to live in two worlds and fitting into neither." Similar explanations have been advanced for higher rates of suicide found among American Indians and Alaska Natives, who are among the U.S. groups with suicide rates that exceed the population average and are rising.

Isolation -- including traits such as extreme independence -- also is frequently invoked to explain the high suicide rates among adult white men in the United States, particularly in the rural mountain West. "They are very independent people, which fits into the profile" for suicide risk, Stephanie Finley, acting director of Colorado's new state suicide prevention office, told the Denver Post this summer.

The isolation/independence factor also has been raised in connection with one of the newest demographic groups to experience rising suicide rates: young African-American males. "We're still gathering data about this, but one of the things we seem to find in African-American communities is that the spirit of self-reliance -- which is good -- is sometimes combined with a sense of shame about mental symptoms and a belief that you should be able to shake off these symptoms by yourself," National Institute of Mental Health (NIMH) Director Steven Hyman, MD, told Ebony magazine in July.

Some scholars advance the controversial theory that black youths may be experiencing a growing sense of cultural isolation akin to that which afflicts aboriginal youth in New Zealand and Australia. Middle-class African-Americans may suffer feelings of isolation that increase the suicide risk for those who have other risk factors such as depression, psychiatrist Carl Bell, MD, of Chicago's Community Mental Health Council told Essence magazine in November 1998. "Many blacks no longer accept you, and whites don't want you either."

While evidence is inconclusive, some data suggest that the sharp increase in African-American male suicide rates is mainly attributable to suicides among young men from middle class professional families. A 1996 Columbia University study, for example, found that black suicide victims tend to come from higher socioeconomic backgrounds than average, the opposite of what's seen among white and Hispanic suicide victims.

But the search to identify the correct risk factors can at least begin among groups for whom it's clear that suicide rates are high or currently increasing. For another group that some would include on the high-risk list

-- gay and lesbian young people -- the questions start with determining whether they actually are at high risk.

The issue already has been the subject of fierce political controversy. A 1989 study by San Francisco-based therapist Paul Gibson that concluded gay youth are two to three times more likely to attempt suicide than other young people was first endorsed then repudiated by the U.S. Department of Health and Human Services (HHS) during the Bush administration. Then HHS Secretary Louis Sullivan, MD, wrote to then-Representative William Dannemeyer (R-CA) that Gibson's views "do not in any way represent my personal belief or the policy of this department....Federal policies must be crafted with great care so as to strengthen rather than undermine the institution of the family. In my opinion, the views expressed in the paper run contrary to that aim."

The problem, according to Peter LaBarbera, executive director of Accuracy in Academia, is that, "voicing concern over suicide risk for 'gay youth,' homosexual activists are pushing pro-homosexual programs in the schools which will invariably ensnare vulnerable teens who might otherwise have avoided the destructive homosexual lifestyle. Their diagnosis: gay youth need affirmation of their homosexuality....The proffered solution: affirmation programs that make gay youths comfortable with being homosexual and the rest of the student population comfortable with the concept of homosexuality."

That recommendation is based on politics, not "scientific assessment," LaBarbera charges. He and others have criticized the Gibson study for focusing on subjects found through gay-oriented organizations rather than in a random population sample, which they say means that the subjects were unlikely to be representative of the gay population generally.

While some research has continued over the past decade, results still are all over the map, and research that would give a definitive answer about gay/lesbian suicide risk hasn't been done, according to psychologist Terry Norman of the Kansas City MO-based National Institute for Gay, Lesbian and Transgender Education. "The research that's out there says that gay youth have anywhere from zero to seven times greater risk," he says.

To professionals who work with gay and lesbian young people, "intuitively, they seem to be at far higher risk," and research is only done on any issue "once a hypothesis is intuitively experienced," says Norman. "So many of my clients have said that at 15 or 21 or 27, they almost succeeded in taking their life." Norman says that a large number of programs nationwide now work to sensitize people to suicide risks, but "virtually none" recognize sexual orientation issues as a factor. He recounts the story of a teenage girl hospitalized several times for suicidal depression. "Anyone looking at that child certainly ought to see that pink was not her color, a dress was not her clothing." Nevertheless, asked whether anyone had talked with her about sexual orientation during her hospitalizations, the answer was, "Nope. Never came up," he says.

"All we want to say is: Please recognize that when you have a suicidal person, explore the orientational component."

The Surgeon General's office seems "totally open" to the possibility that gay and lesbian young people are an at-risk group that should be targeted in a national strategy, says Norman. "But we've got to have scientific evidence that justifies that decision."

Analysis of other at-risk populations that finds social and cultural

isolation can be a strong risk factor suggests that young people confused about sexual orientation might experience similar risk. But definitive research is far harder to produce for a demographic group with which many may be loath to identify themselves.

Studies conducted among young people who self-identify as gay lack the statistical certainty of random studies. But in studies of a random cross-section of young people, it's nearly impossible to be sure that all of those who are troubled about sexual orientation have been identified. Some such studies attempt to identify whether young suicide victims are gay or lesbian using markers such as whether they've spoken to friends about sexual orientation or had gay friends. However, many of the young people most troubled by possible homosexual feelings may be the least likely to have such a history.

Developing Interventions

"Efforts by NIMH-sponsored investigators to find proven and safe prevention efforts are a work in progress," and the obstacles are "formidable," NIMH's Hyman told a Senate appropriations panel in February. "It is challenging to convince researchers to pursue careers in suicide prevention, given the difficulty of showing a reduction in suicidal behaviors over the typical, five-year funding period of an intervention study. To demonstrate effects, particularly within this time frame, would require trials of very large size. Also, most researchers who received funding from NIMH for clinical trials traditionally have excluded suicidal patients...as does the pharmaceutical industry" because of fear of legal liability.

The AFSP is pushing for publicly and privately sponsored controlled trials of suicide treatments in the United States, Mann told the panel. "Such studies are ethically feasible because we can compare two active treatments, where one...is thought to have a specific...advantage for preventing suicide...in addition to ameliorating the psychiatric illness, and yet patients in both groups will get a treatment known to be effective for their primary psychiatric disorder."

Up to now, "the few relevant studies" find that many treatments effective for depression, schizophrenia, anxiety, and substance abuse "have no demonstrable effect on suicidality," according to Alan Lipschitz, MD. "The clearest example: while many studies show anti-depressant and mood-stabilizing medications effective in relieving depression, only one drug -- lithium -- consistently reduced the suicide risk."

With no guidelines and little evidence-based data, treatment received by suicidal patients varies almost randomly from treatment center to treatment center, says Lipschitz. Worse, "We may not even recognize our interventions constitute a suicide-preventing treatment worthy of study."

"When a patient enters an emergency room threatening suicide, is interviewed, and is sent out; when a cocaine user threatening suicide is admitted to the hospital and spends the next three days in a cocaine withdrawal 'crash'...and then is discharged...suicide prevention is the focus of treatment interventions that are cryptic and little studied," he says. "What are the therapeutic elements in these interventions? The recognition by abject patients that they merit support...that they can feel some measure of relief and are not doomed to descend inexorably into further suffering....Studying, understanding, and perfecting the interventions of this critical period is crucial for improving our ability to prevent suicide."

One intervention strategy that many agree should be part of a comprehensive program could raise significant political opposition to suicide prevention efforts in some areas: reducing access to the means of suicide.

The relationship between suicide rates and access to suicide means is not entirely clear. Some studies suggest "that restricting access to a particular means of suicide results in a reduction...in the overall rate," says the New Zealand government's research review. However, "other studies suggest that restriction of access to one method of suicide results in the substitution of that method by another."

Rates in many countries whose citizens have limited access to guns are higher than U.S. rates. New Zealand for example, had a male suicide rate of 23.4 per 100,000 population in 1996; in Finland, the rate was 38.7 per 100,000. That's compared to a U.S. rate of around 18.6 per 100,000. In the United States, 61.6 percent of male suicides used a firearm or explosive. In the other nations, hanging and poisoning were more common.

But an AFSP-sponsored study by David Brent, MD, and Joshua Perper, MD, found "that suicide victims from armed homes had psychiatric disorders less often than did the suicides from gunless homes." That suggests that "suicide in the absence of clear psychiatric illness is greatly facilitated by having a readily available firearm...The danger of the gun resides in its lethal accessibility, enabling disinhibited, impulsive persons to enact their suicide impulse" possibly raising risks for adolescents, for example, for whom impulsivity connected with alcohol and drug abuse is a risk factor.

Bringing the debate over gun control into the suicide prevention effort could muddy the waters beyond recall, some analysts fear. However, it will be hard to put aside the question of access to loaded guns when the strategy of restricting access to other means certainly will be used. In Washington DC, for example, data gathered from the 1986 blocking of a notorious local "suicide bridge" now indicate that restricting access to that bridge at least has not led to an increase in jumps from other nearby bridges and may be holding down the overall suicide rate.

Improving Access

Some interventions that already are in wide use were implemented before they'd been properly tested, suicide experts say. Notable among these: suicide crisis hotlines and school-based awareness programs.

"When a crisis hotline is introduced in an area, the suicide rate remains unchanged," says Columbia University researcher David Shaffer. "Many suicidal individuals (especially men) do not use them; many suicidal individuals are not interested in changing their plans; some are too disturbed to call."

Awareness programs aimed at young people should be carefully evaluated before they are used, according to Hyman. Few have been shown to work, and, worse, "some programs have had unintended negative effects by making at-risk youth more distressed and less likely to seek help." Some awareness programs unintentionally "normalize" suicide, making it appear to be a coping option that's fairly routinely chosen by people who don't suffer from mental illness; that can raise the likelihood that other adolescents will begin to consider suicide a viable option, according to Hyman and others.

Some more successful teen prevention strategies have been developed and

evaluated, researchers say. Systematic screening via a confidential questionnaire of a large number of young people for mental health problems and referring those with identified serious difficulties for followup counseling can pick up most teenagers with the biggest risk factors, according to Shaffer.

A public awareness campaign that informs teenagers about the warning signs and encourages them to tell an adult who can help if a friend exhibits them is being launched by AFSP with private funding and an endorsement from Satcher, says executive director Bob Gebbia. "We know from research that often kids hide from adults but tell their friends. We're urging the friends to tell somebody even at the risk of making a friend angry."

Increasing access to mental health care is a recommended intervention that faces practical as well as some political difficulties. For one thing, suicide rates tend to be high in remote, rural areas, the very places where it's difficult to place health care practitioners, particularly on a long-term basis. And high turnover rates among mental health providers can be nearly as troublesome for suicidal patients as lack of a provider, since trust is an important element of the clinician-patient relationship, some experts say.

Furthermore, having physical access to health care doesn't mean that people in need will make adequate use of it. For example, "the concept of access emerged as central" to Australia's teen suicide prevention effort, according to the AIFP evaluation. However, "prevention programs have particularly failed to adequately engage young males and young people with complex psychosocial problems." Providers must not only be available; they must learn how to communicate with young people. "Assertive follow-up is particularly critical for ensuring that young people at high risk are provided with the encouragement and practical assistance to return to services once initial contact has been made."

Similar access issues afflict white adult males -- the U.S. group that has the highest suicide rate. We "need to focus on how to get men into the system better, to accept the treatment," says Allan Berman, head of the American Association of Suicidology. "Women are better at accepting treatment."

Bringing suicide awareness into the workplace as well as the political hot potato of requiring equal health insurance coverage for mental health care also are key access issues for adult men, says Col. David Litts, who directed the U.S. Air Force's successful initiative to lower its suicide rate during the 1990s and now serves as Special Advisor to Satcher.

"Half the people who commit suicide are working-age adult males, and a large proportion are working," says Litts. "They need health benefits that cover mental health as well as access to employee assistance programs that help solve life issues." Corporate wellness programs as well as corporate cultures overall need retooling to accomplish this, Litts says.

Finally, there's money. Private funding for suicide research and intervention has been hard to come by, according to Norman, Gebbia, and others. A handful of corporations and foundations have stepped up -- Norman names the Bank of America in Kansas City, Gebbia the Ronald McDonald House Foundation and the Soros Foundation -- but most have been reluctant.

Federal funds still are slim. Congress authorized \$75 million for youth suicide prevention when it reauthorized the Substance Abuse and Mental Health Services Administration and established some other programs in the Children's Health Act of 2000; no funds have been appropriated for the act,

however. Fiscal year 2001 appropriations for HHS include \$3 million for certification of suicide prevention programs. But that legislation awaits the lame duck congressional session slated to begin Nov. 13, and some health lobbyists are predicting that the bill may be dead, replaced by continuing resolutions that would fund federal departments based on last year's appropriations, perhaps until fiscal year 2002 appropriations are enacted.

Suicide experts generally agree that the public health community will continue to work toward suicide prevention, difficulties aside. Early public health programs tackled infectious diseases, says Berman." And to the extent that the disease comes from a single agent, that's been easier. Nevertheless, it took 200 years to do something about smallpox. To really make strides against suicide, it's going to take centuries."

-- MC

Healthcare Information Center

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Concept Terms: All government; All market information; Demographics; Government finance
Geographic Names: Australia & New Zealand (AUNX); European Union (EUCX); Finland (FIN) ; New Zealand (NEZ); North America (NOAX); Pacific Rim (PARX); Scandinavia (SCAX); United States (USA); Western Europe (WEEX)

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Challenges of state health reform: Variations in ten states

Cantor, Joel C; Long, Stephen H; Marquis, M Susan
 Health Affairs v17n1 pp: 191-200
 Jan/Feb 1998

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Abstract:

The key findings from the 1993 Robert Wood Johnson Family Health Insurance Survey, which interviewed more than 27,000 families in 10 states, are examined. There is considerable variation among the states in insurance coverage, health status, and access to care of both adults and children. Moreover, states with higher percentages of uninsured residents also have populations with lower health status and more access problems. This clustering of problems in certain states may make health care reform even more challenging for their elected officials to accomplish.

Text:

Headnote:

Estimates abound on how many Americans lack insurance coverage. A new survey of families uncovers new challenges for states in crafting their own strategies for the uninsured.

Headnote:

ABSTRACT: This DataWatch reports on the key findings from the 1993 Robert Wood Johnson Foundation Family Health Insurance Survey, which interviewed more than 27,000 families in ten states. There is considerable variation among the states in insurance coverage, health status, and access to care of both adults and children. Moreover, states with higher percentages of uninsured residents also have populations with lower health status and more access problems. This clustering of problems in certain states may make health care reform even more challenging for their elected officials to accomplish.

ONLY A FEW YEARS AGO national health care reform was at the center of health policy discussions. Over a longer period, several states have shown interest in health care reform, and some of them have legislated and implemented reforms.² Now Congress and the Clinton administration have joined them by expressing strong interest in increasing state flexibility and responsibility for reform. For example, the Clinton administration has strongly supported Section 1115 Medicaid waivers, and the new State Children's Health Insurance Program (CHIP), signed into law as part of the Balanced Budget Act of 1997, relies on federal grants to participating states, which will design and administer the program.³

The problems to be corrected by health care reform have been well documented for the nation as a whole. We know a good deal about the number of uninsured Americans, their characteristics, and the implications of being uninsured for access to health care and use of services.⁴ On the other hand, as the focus shifts to the states, it is important to ask if these national patterns represent the circumstances of all states equally well. To put it another way, does each state need to overcome the same health care problems in degree and in kind? Although we do have estimates of variation in the uninsurance rate by state from a national survey, there is limited comparable information on state circumstances along several other problem dimensions.⁵

The Robert Wood Johnson Foundation (RWJF) launched a program, State Initiatives in Health Care Reform, in 1991 to award grants to individual states to assist them with the process of designing and implementing health care reforms.⁶ The grantee states were selected, in part, for their geographic diversity, the extent of uninsurance, and the proposed approach to reform. Although the grantee states were required to have a clear, prospective plan for health care reform, they varied widely in the extent of previous reforms, and several of them had no history of reform.⁷ As part of the RWJF program, we developed and fielded two surveys to better understand the states problems, analyze policy options, and collect baseline data to support subsequent evaluation of outcomes. An earlier report described results from the Employer Health Insurance Survey.⁸ In this paper we report key results from the Family Health Insurance Survey.

Study Methods

The RWJF Family Health Insurance Survey was conducted in the latter half of 1993 and early 1994 in Colorado, Florida, Minnesota, New Mexico, New York, North Dakota, Oklahoma, Oregon, Vermont, and Washington State.⁹ It collected detailed information on insurance status, as well as information on demographic characteristics, employment, income, health status, access to health care, and use of health services.¹⁰ Response rates ranged from a low of 61 percent in New York to a high of 83 percent in North Dakota. More than 2,000 twenty-five-minute telephone interviews were conducted with families in each state, supplemented by 100-200 in-person interviews in households having no telephone. This yielded a total of 27,138 families containing 62,549 persons across the ten states. Families with Medicaid enrollees or uninsured persons were oversampled using a general population telephone screening interview. The Medicaid population identified in the screening interview was supplemented by sampling from program enrollment lists in nine of the ten states. Finally, households without telephones in a few geographic areas in each state were identified and interviewed in person.

The interview unit was the family. Within each family, the survey collected all data items for all adults; insurance and other characteristics were collected for all children, but health status and service use for only one randomly selected child per family.

We used sample weights to make estimates. The weights adjust for the probability of selection and for differential nonresponse among subgroups of families. The estimates are for the nonelderly population and are provided separately for adults and children. All insurance and health status estimates refer to the day of the interview. The estimates of health service use and measures of access problems-not having a usual provider and not receiving selected health services-refer to various reference periods preceding the interview.

Study Findings

Overall, the ten survey states are quite representative of all fifty states in the average level and variability of several important population, health care system, and health policy characteristics (Exhibit 1). For example, personal income per capita in 1993 was \$20,800 in all states and \$21,770 in the ten survey states, while the range was \$14,745-\$28,151 over all states and \$16,295-\$24,844 over the ten survey states. To cite another example, the survey states cover nearly the complete range of generosity in Medicaid program eligibility, as measured by the ratio of Medicaid recipients to the population in poverty. Measures of variation in managed care penetration and the supply of hospitals and physicians also are very

similar.

Extent of insurance coverage. The health care circumstances of people in the ten study states vary substantially (Exhibit 2). The percentage of the nonelderly population without health insurance coverage in 1993 varied nearly threefold, from 27 percent in New Mexico to 10 percent in Minnesota. The percentage of uninsured persons is lower for children (under age eighteen) than it is for adults (ages eighteen to sixty-four) in nine states. However, the range of variation among the states in the percentage of uninsured persons is greater for children (ratio of the high to low state is 4.0 to 1) than it is for adults (2.5 to 1).

Health status and access. Key measures of health status and access to care follow a similar pattern (Exhibit 2). The percentage of adults and children reported to be in fair or poor health (on a fivelevel scale) or reported to have no usual source of medical care other than an emergency department are highest in the states with a high percentage of uninsured persons.¹¹ As we observed in patterns of insurance coverage, there is more interstate variation among children than there is among adults. The ratio of the high to the low state on both measures is at least twice as great among children as it is among adults.

High-uninsured states versus low-uninsured states. In the exhibits that follow, we examine insurance coverage, health status, and access in greater depth. In each, we group the three states with the highest percentage of uninsured persons and the three states with the lowest percentage of uninsured persons. Specifically, we compare circumstances in Florida, New Mexico, and Oklahomathe high-uninsured states-with those in Minnesota, North Dakota, and Vermont-the low-uninsured states.

(Table Omitted)

Captioned as: EXHIBIT 1

(Table Omitted)

Captioned as: EXHIBIT 2

These and the estimates that follow are based on simple means of the separate estimates for the three individual states (that is, they are not weighted by each state's population), because our objective is to use these states as observations to characterize circumstances in similarly situated states that were not studied. In contrasting the patterns for high- and low-uninsured states, we examined the conditions for the middle four states grouped (not shown in the exhibits). With the exception of one measure (childhood immunization compliance), estimates of health care problems for the middle four states fell between those for the high- and low-uninsured states.

Insurance coverage. Exhibit 3 shows the distribution of public and private health insurance coverage of adults and children. The interstate variation in the uninsured rate for each age group is mirrored by differences in the rate of private coverage, but the percentage with public coverage in each age group varies little among the states.¹² Therefore, the relatively wider interstate spread in the percentage of children without coverage-also seen in Exhibit 2stems from wider variations in the rate of private coverage for them.

Health status. Persons living in states with a higher percentage of uninsured persons are also more likely to be in ill health. Adults and children are each about twice as likely to be reported in fair or poor

health in the three high-uninsured states compared with the three low-uninsured states—a gap of six percentage points among adults and two percentage points among children (Exhibit 4). Also, the percentage of adults limited in the kind or amount of vigorous or moderate physical activity (for example, lifting heavy objects, moving a table, or carrying groceries) is modestly higher in the high-uninsured states.¹³

(Table Omitted)

Captioned as: EXHIBIT 3

Access to care. The measures of access to care shown in Exhibit 5 reveal greater problems in the three states with the highest percentage of uninsured than in the three low-uninsured states. The first two measures of poor access—lack of a usual source of care (other than the emergency department), and not receiving emergency care when needed—are two to three times higher in the high-uninsured states. The rates of these access problems are higher for adults than they are for children.

We also examined four other, less subjective measures of access to care (Exhibit 5). First, among adults and children the percentage with no doctor visit in the year prior to the survey is about 1.2 and 1.5 times greater, respectively, in the high-uninsured states than in the low-uninsured states. This difference prevails despite the fact that people in the high-uninsured states are in poorer health, which should make them more likely to have seen a physician. Three measures of preventive services use show similar patterns. The percentage of women ages nineteen to sixty-four who fail to receive a recommended Pap smear, the percentage of women ages forty-one to sixty-four who fail to obtain at least one mammogram, and the percentage of children ages two to four who fail to receive at least one recommended immunization were between 1.2 and 1.5 times greater in the high-uninsured states.¹⁴

Discussion

(Table Omitted)

Captioned as: EXHIBIT 4

(Table Omitted)

Captioned as: EXHIBIT 5

In the current political environment, much of the responsibility for improving health care access and affordability is vested in governors and state legislatures rather than in the federal government. The new CHIP provides federal funds to assist states in providing coverage to their low-income, uninsured children. However, to participate in CHIP, states also must contribute payments to the program and make many decisions about its design.¹⁵ In this DataWatch we found considerable interstate variability in the health insurance coverage of children. While the percentage of uninsured children is lower than the percentage of uninsured adults in most states, still almost one-quarter of all children are uninsured in the three states with the highest uninsured rates. Thus, the ease with which some states would have been able to take significant steps on their own to close the gap in the care of children may be less than widely believed. This suggests that federal support for states' efforts, as embodied in CHIP, is well placed. This program may help to diminish the disparity we now see among states in the rate of uninsured children.

We find that health care problems cluster within states: Those with the highest percentages of uninsured persons also have lower levels of average

health status and higher levels of access problems. States with both a high percentage of their population without insurance and with low health status will have to spend more per capita than other states spend to attain equivalent outcomes. The substantial variation suggests that a strategy relying on incremental, state-by-state action is likely to leave the nation with significant lingering gaps in the health care of many Americans. While some states such as Minnesota and Vermont may be expected to redress a significant part of their respective health system problems, the challenges to other states such as Florida, New Mexico, and Oklahoma are far greater.

Although our results provide a better quantification of the problems state health reformers face, their policy implications are not entirely clear. We observe considerable clustering of various problems among states with the highest rates of uninsurance. Yet from the data presented here, we cannot discern whether this represents the coincidence of several different problems, each requiring a different policy remedy, or the single core problem of inadequate rates of insurance, with the obvious policy implication to expand coverage. There is a well-documented connection between lower rates of coverage and poorer access to medical care, but we cannot be sure that this is the only cause of the access shortfalls that we observe among the states. Moreover, it is possible that the lower levels of health status in the high-uninsured states merely reflect the effects of long-standing insurance coverage gaps and correspondingly poorer access to care. On the other hand, the observed health status differences also could be the result of differences in income, educational attainment, housing, and nutrition, to name a few possibilities. Until these more complex relationships can be sorted out through further research, it would be premature to conclude that health care reform either is or is not simply a matter of insurance coverage expansions. But they might be a good place to start.

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Footnote:

NOTES

1. See, for example, T. Skocpol, "The Rise and Resounding Demise of the Clinton Plan," *Health Affairs* (Spring 1995): 66-85; and H. Heclo, "The Clinton Health Plan: Historical Perspective," *Health Affairs* (Spring 1995): 86-98. 2. See, for example, D.L. Rogal and W.D. Helms, "State Models: Tracking States' Efforts to Reform Their Health Systems," *Health Affairs* (Summer 1993): 27-30; E. Friedman, "Getting a Head Start: The States and Health Care Reform," *Journal of the American Medical Association* (16 March 1994): 875-878; D. Neubauer, "Hawaii: A Pioneer in Health System Reform," *Health Affairs* (Summer 1993): 31-39; H.M. Leichter, "Minnesota: The Trip from Acrimony to Accommodation," *Health Affairs* (Summer 1993): 48-58; and R.A. Crittenden, "State Report: Recent Action in Washington and Oregon," *Health Affairs* (Summer 1995): 302-305.

Footnote:

3. J. Holahan et al., "Insuring the Poor through Section 1115 Medicaid Waivers," *Health Affairs* (Spring 1995): 199-216; B.C. Vladeck, Medicaid 1115

Demonstrations: Progress through Partnership," Health Affairs (Spring 1995): 217-220; and State Children's Health Insurance Program," Title XXI, Social Security Act, 1997, sec. 2101(a).

4. J. Holahan, C. Winterbottom, and S. Rajan, "A Shifting Picture of Health Insurance Coverage," Health Affairs (Winter 1995): 253-264; P.W. Newacheck, D.C. Hughes, and M. Cisternas, "Children and Health Insurance: An Overview of Recent Trends," Health Affairs (Spring 1995): 244-254; D. Rowland et al., "A Profile of the Uninsured in America," Health Affairs (Spring II 1994): 283-287; and S.H. Long and M.S. Marquis, "The Uninsured Access Gap and the Cost of Universal Coverage," Health Affairs (Spring II 1994): 211-220.

Footnote:

5. For estimates based on pooling adjacent years of the Current Population Survey, see C. Winterbottom, D.W. Liska, and K.M. Obermaier, State-Level Databook on Health Care Access and Financing, 2d ed. (Washington: Urban Institute, 1995); and J.D.C. Cartland and B.K. Yudkowsky, "State Estimates of Uninsured Children," Health Affairs (Spring 1993): 144-151. For a comparison of the CPS estimates and those from the survey data used in the present paper, see S.H. Long and M.S. Marquis, "Some Pitfalls in Making Cost Estimates of State Health Insurance Coverage Expansions," Inquiry (Spring 1996): 85-91. For information about insurance coverage and access to care for the low-income population in five states, see C. Schoen et al., "Insurance Matters for Low-Income Adults: Results from a Five-State Survey," Health Affairs

Footnote:

(September/October 1997): 163-171.

6. Robert Wood Johnson Foundation, Call for Proposals: State Initiatives in Health Care Financing Reform (Princeton, NJ.: RWJF, October 1991). 7. Robert Wood Johnson Foundation, State Health Care Reform: Looking Back toward the Future (Princeton, NJ.: RWJF, September 1997). 8. J.C. Cantor, S.H. Long, and M.S. Marquis, "Private Employment-Based Health Insurance in Ten States," Health Affairs (Summer 1995): 199-211.

9. For details of the survey design and methods, see Mathematica Policy Research, Survey Design and Data Collection Methods for the Robert Wood Johnson Foundation's Family Survey on Health Insurance (Princeton, NJ.: MPR, 14 September 1994). The data cleaning procedures are described in L.M. Andrews, S.H. Long, and M.S. Marquis, Data Cleaning Procedures for the 1993 Robert Wood Johnson Foundation Family Health Insurance Survey, MR-862-RWJ (Santa Monica, Calif.: RAND, 1997).

Footnote:

10. In addition to the customary types of insurance coverage collected in national surveys (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services, Department of Veterans Affairs, employment-based, and other private), the survey included state-specific probes for special subsidized insurance programs by name in states where they were available. 11. These comparisons do not directly adjust for differences among the states in their demographic profiles. However, there is some age standardization in limiting the comparisons to persons under age sixty-five and in comparing adults and children separately. Nonetheless, there may be differences in the composition of the states populations that relate both to insurance status and access.

Footnote:

12. In contrast, Cathy Schoen and colleagues, in "Insurance Matters for LowIncome Adults," found that differences in the number of uninsured among low-income adults in the five states included in the Kaiser/Commonwealth survey were mirrored by differences in Medicaid coverage, rather than by differences in private insurance. The Kaiser/Commonwealth survey was administered after recent expansions in the Medicaid program in several of the states. In addition, differences in the populations covered in the two surveys (all persons versus the low-income population) might have contributed to the different findings.

13. The survey did not include questions about physical limitations among children.

Footnote:

14. American Cancer Society, Cancer Facts and Figures-1997 (Atlanta, Ga.: ACS, 1997), 29. Children were classified as not being in compliance with recommended immunizations if they were reported as not having received any one of the following vaccinations: diphtheria, pertussis, and tetanus (DPT); poliovirus; or measles, mumps, and rubella (MMR). Age-specific immunization recommendations are based on Centers for Disease Control and Prevention, "Immunization of Adolescents: Recommendations of the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American Medical Association," Morbidity and Mortality Weekly Report (22 November 1996): 3. 15. See S. Rosenbaum et al., "The Children's Hour: The State Children's Health Insurance Program," Health Affairs (January/February 1998): 75-89.

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Descriptors: Polls & surveys; Health care policy; Uninsured people; States; Reforms; Statistical analysis

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6/9/3 (Item 2 from file: 15)

DIALOG(R)File 15: ABI/Inform(R)

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Changing times and the business case for "telestuff"

Burns, Patrick
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Abstract:

Health care organizations must adapt to a changing environment and new business rules, and telemedicine has the potential to improve the quality of care, expand access to care, and reduce costs. Advances in client-server technology coupled with a new health care business environment are opening doors to new and less expensive telemedicine solutions. However, to be done successfully, telemedicine has to clearly meet the organization's mission statement and be within the vision of key executives - everybody from the board of directors to the practicing health care provider.

Text:

Headnote:

Advances in client-server technology coupled with a new health care business environment are opening doors to new and less expensive telemedicine solutions.

Health care organizations must adapt to a changing environment and new business rules. Telemedicine has the potential to improve the quality of care, expand access to care, and reduce costs.

My experience with telemedicine goes back to the late 1980s when I was chief information management officer - a CIO-type of position at Brooke Army Medical Center in San Antonio.

Then, it was true in the Department of Defense and Veterans Administration systems, as it was in the civilian medical community, that if you did more work and did more procedures, you made more money. That was profit under the old paradigm of fee for service.

In today's world with capitation, HMOs and PPOs - the whole concept of reward and incentives has been turned on its head.

With a capitated population, we make a profit if we do less. That's basically our target to work against to provide health care. So the emphasis for the military as well as the commercial world is to try to give the same high quality of service, and maybe even improve that, and at the same time not limit access.

The key is to do it in a controlledcost environment. The way to do that is to look at how to better utilize assets.

With an integrated delivery system covering a wide geographic area, it is not affordable to have specialists and very expensive equipment in multiple locations. Assets need to be centralized.

However, if you do not implement a network or a communications infrastructure, the patient population would be penalized because they would have to go to a central facility. Or conversely the health care specialist would have to do a circuit around the area visiting patients.

We think there is a clinical business case and a pure business case to implement the technology called telemedicine and teleradiology what I like to call "telestuff."

Making it work

To be done successfully, telemedicine has to clearly meet the organization's mission statement and be within the vision of key executives - everybody from the board of directors to the practicing health care provider. Otherwise, it will not work.

Before attempting to implement telemedicine it is important to do a baseline survey of the automation capabilities among the different hospitals that are going to be sharing a telemedicine project. A successful telemedicine project begs that there is a preexisting commonality of relationships, automation and infrastructure.

For example, if hospital "A" has an SMS system, hospital "B" has an HBOC system, and hospital "C" has a Cerner system, each will probably have different patient identification matrixes. There might not be a master patient index within the area and telemedicine will not overcome that.

If clinicians think telemedicine will magically bridge the gap from one system to another, that's just not the case.

If in fact you want to do telemedicine between a physician in rural Kansas and Johns Hopkins, and there is not existing communications in place, at least by phone, fax or e-mail, to implement telemedicine is a giant leap.

If nothing else, if health care facilities were providing a common email system among themselves and health care providers were communicating by e-mail, that's telestuff. It's low-end telemedicine but it's good telemedicine.

If a region of facilities does not have that kind infrastructure in place, the million dollar question is: "Are they willing to commit the resources to implement that infrastructure?"

That will be the biggest cost of any telemedicine project. It won't be the telemedicine boxes -- either the PCs or codecs that would go inside a facility - but the communications. There's a one-time cost of buying the boxes and then the recurring costs of communications. My belief is the recurring costs of communications will be the biggest problem and that cost will far exceed the initial acquisition of the PCs and codecs.

Before purchasing a system, a baseline survey of facilities' equipment needs must be done. Analyze the integrated delivery system and look at referral patterns. I also think administrative and health care provider buy in and leadership has to be present. Then the infrastructure costs need to be measured and supported.

It would be criminal to implement a telemedicine program without the board of directors knowing about recurring costs. There needs to be a business plan similar to any capital investment: Measure the one-time costs and measure the recurring costs.

Challenges for telemedicine

Any potential candidate for implementing a telemedicine program should look at a number of non-clinical and non-technical challenges. Most are legal and ethical.

I would suspect that chief financial officers raise their hands and ask "How much money am I going to save?"

There is not a lot of referenced literature out there that really shows that telemedicine saves money. It's an implied assumption. It's a gut feel. It's a common sense, "Yeah, I think it's got to be, but who knows?"

Telemedicine has to be a joint planning and implementation partnership between IS support and clinical ownership.

Any successful project that I've seen needs clinical leadership along with technical support.

Another challenge is reimbursement. Some state laws prohibit reimbursement for telemedicine. Therefore, it's not a business incentive. It will change over time, probably on a state-by-state basis. California was the first to change the laws on a statewide basis, and Georgia has done it on a test basis.

Integrating telemedicine into computerized patient records (CPR) is also a challenge. Providers will balk if they perceive telemedicine as more workload, adding additional steps and reducing their time with patients.

Other challenges include areas such as licensure when practicing across state lines, credentialing and liability. The issue of privacy and confidentiality, particularly if the data is unencrypted or where the Internet is considered, needs to be addressed as well.

Also, telestuff is traditionally viewed as interactive video. That's why its historically thought of as so expensive. Most programs use real-time interactive stuff, but my belief is "store-and-forward technology" makes more sense. I suspect store-and-forward telemedicine will be 80 percent to 20 percent [real-time] in most regions.

Store-and-forward

With store-and-forward technology, you don't have to pay for expensive equipment and communications lines.

A clinical folder could be prepared, sent over low-cost communications media, and opened for review and consultation at a later time. This consulted folder could be returned to the sender via the same low-cost communications media.

I think store and forward integrates nicely into the practice of medicine, avoiding the video conference equipment and basically avoiding the expensive cost of communications. It mirrors better the way a patient consult is done today. Future telestuff initiatives should be a mixture of both interactive and store-and-forward technologies.

The future of telemedicine

Increased computer power at lower cost, increased bandwidth at lower cost, the Internet, the explosion of software tools and operating systems; all have created a compelling technical capability for telemedicine at the desktop. Desktop video conferencing and collaborative computing are also pushing this trend.

Telestuff is not going to be viewed as a single entity, but as a key component of an enterprise solution. Telemedicine is currently viewed as a tool to allow health care providers to overcome time and distance barriers. I think telemedicine is a concept of pushing the idea of multimedia to the desktop.

Health care is an extremely multisensory industry. It is more than say, the exchange of spreadsheets and text used for banking applications.

Viewing the patient, seeing Xrays, viewing still and motion images, hearing sounds, seeing text and numerical data - is all part of the numerous data sets health care providers work with.

Telestuff will become part of the health care record available across the enterprise.

Computers can provide the ability to capture and even record patient specific data, and compare it with population general data. Protocols, rules and pathways can be developed to measure and improve outcomes.

Sidebar:

Are you ready for "telestuff?"

Sidebar:

- * Within your region, if there is limited specialty care, or it's located in pockets - not pervasive - then telemedicine can work.

- * It can work when there is a high cost of patient transfer or physician transfer - such as patient movement into a facility or physician movement out of the facility to go to the patient's area to provide care.

- * If the area has limited laboratory, pathology or radiology capabilities, telemedicine can serve as an enabling technology.

- * If there are limited opportunities for continuing education, videoconferencing might be used beyond treating patients. It can be used as a continuing education tool for all health care providers and selected patients.

- * Telemedicine can overcome a sense of professional isolation as well. If health care providers in a community do not see a diverse case mix, they're going to get professionally stale and may decide to leave that area. Telemedicine -- particularly videoconferencing - can keep them involved in some of the more complex health care cases that occur. "Virtual rounds" can help keep them stimulated and current to what's going on in their discipline.

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Geographic Names: US

Descriptors: Telemedicine; Trends; Health care industry; Client server computing

Classification Codes: 9190 (CN=United States); 5240 (CN=Software & systems); 8320 (CN=Health care industry)

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How to evaluate pharmacy benefit offerings

Stern, Craig S

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Abstract:

There are many offerings from health plans, pharmacy benefit managers (PBM), and disease management (DM) companies to control the cost of prescription drugs. The pharmacy benefit cost is a factor of the actual ingredient cost of the medication and the number of prescriptions dispensed. The single most effective factor in decreasing the ingredient cost of medications is generic substitution. The single most effective factor for decreasing the number of prescriptions dispensed is for the physician to prescribe or the pharmacist to recommend over-the-counter medicines. In order to contain costs beyond the generic substitution rate and benefit exclusions, further restrictions on choice must be implemented. In the undifferentiated PBM market, the introduction of DM programs should improve the overall quality of the health care delivered.

Text:

There are many offerings from health plans, pharmacy benefit managers (PBMs), and disease management (DM) companies to control the cost of prescription medications. Which of these offerings really control costs? Do cost containment tools compromise quality? Do restrictions on choice create access problems? Which of the offerings provide value and which are just appealing?

DIRECT COST CONTAINMENT

The pharmacy benefit cost is a factor of the (1) actual ingredient cost of the medication and the (2) number of prescriptions dispensed. The single most effective factor in decreasing the ingredient cost of medications is "generic substitution." The generic substitution rate for commercial programs is usually in the 35%-40% (of total prescriptions) range. For Medicare programs, the generic substitution rate is in the 20%-30% range.

The single most effective factor for decreasing the number of prescriptions dispensed (i.e., utilization) is for the physician to prescribe or the pharmacist to recommend over-the counter (OTC) medicines. This tool is useful in controlling health plan costs because most health plans/insurance companies do not pay for OTC medications. As more prescription medicines become available OTC, consumer discretion, as influenced by the marketplace, will drive the choices for self treatment (see related article on page 24).

Benefit plan design is effective as a cost containment tool only so far as it excludes medications or categories of medications. However, plan design is not an effective control on drug utilization, so physician prescribing patterns may still continue to drive overall costs upward.

INDIRECT COST CONTAINMENT

In order to contain costs beyond the generic substitution rate and benefit exclusions, further restrictions on choice must be implemented. These restrictions usually are implemented through formularies, therapeutic substitution, and prior authorization programs.

Formularies (restricted listings of prescription drugs covered in a health plan) reduce the number of choices that physicians have to prescribe for their patients, and therapeutic substitution reduces the number of agents that provide the same therapeutic effects. The use of formularies is based on the reasoning that, because there are many categories of agents that contain similar or negligibly different products, the total number of choices can be reduced. The marketplace has provided a plethora of similar agents, allowing competitive bidding to determine the agents that are included in a formulary and the ones that will be therapeutically substituted for a similar benefit. Formularies also use generic substitution as a basis for cost containment.

Prior authorization mechanisms may be introduced in an attempt to monitor for quality using best practices or clinical algorithms as benchmarks. These quality checks are currently packaged as part of the value of the program being offered rather than a carved-out cost.

Closed or selective formularies (plan coverage is restricted to listed drugs) may increase access problems and provider-to-provider-to-patient miscommunication. However, closed formularies do restrict choice for branded medications (i.e., those medications that cannot be generically substituted). To balance the goals of cost containment with an acceptable level of access, the key question is how much additional savings are

provided by a closed formulary over and above the savings provided by generic substitution. To assess these issues it is necessary to question the provider/ insurer about its average generic substitution rate and the actual dollar savings delivered. The same question should be asked of the closed formulary programs (if they are distinguishable). If quantifiable savings are lacking, the only potentially identifiable cost savings from these tools is lower premium rates when the benefits of competitive bidding by the insurers/PBMs is passed on to the customer.

TOTAL QUALITY MANAGEMENT

Drug utilization review (DUR) programs are the analytical "traffic cop" of the formulary. DUR identifies high utilizers and high risk drugs, categories, providers, etc. The actual benefit of a DUR program is to identify cost outliers. Action must be taken to ensure that the identification of quality or cost issues is not for academic interest. DUR should result in a lowering of the overall benefit cost. However, high cost analyses bias actions toward cost reduction instead of necessary therapeutics, especially for chronic treatments utilizing branded products.

Measures should be requested/required of health plans/insurers to ensure that quality is not compromised by cost shifting between the pharmacy benefit and other medical expenses. These measures should include the rates of hospital admissions and emergency room visits and the rates of severe drug-induced problems requiring medical interventions that are otherwise considered avoidable. (Comparisons of these measures between health care providers may result in competitive pressures that drive quality improvements.)

Identification of drug interactions and adverse drug reactions (ADR) can have a significant impact on the overall care of a patient population. The benefits may accrue to the value of the pharmacy benefit as well as to the overall medical plan. The effects of drugs may overlap to shift health care burdens to emergency rooms, hospitals, physician encounters, etc.

However, the provision of a drug interaction/ADR program does not necessarily warrant additional fees. Providers may ignore warnings that are not applicable to specific patients or for want of time. It is necessary to know the expectations at the onset and how the effectiveness of the program is to be monitored. Merely identifying problems is insufficient. There must be an audit trail to ensure that action has been taken and that significant problems have been corrected.

The fees to be paid for total quality management (TQM) efforts should not be based on the transaction or on the savings, but rather on the benefits of a TQM program in improving quality and decreasing bottom-line costs. The customer may share in the benefits of these programs through lower fees and/or quantifiable quality improvements.

PHARMACY BENEFIT MANAGEMENT

PBMs make money by adjudicating claims, collecting rebates from contracting with drug manufacturers, and filling prescriptions through wholly owned mail-order pharmacies. They generally have no incentive to decrease the number of prescription claims, because the PBM would lose the transaction fee.

The PBM industry often is characterized by undifferentiated offerings and poor service. Access problems and poor customer service are usually the product of poor inter-provider communications, providers who are motivated by cost control rather than performance measures, and access problems from restricted provider panels and closed formularies. The PBMs negotiate

favorable rates by restricting provider panels, which are similar to supplier bidding, and focusing purchasing on fewer products through closed formularies.

The benefit to the customer should be evident in competitive rates and lower overall fees. However, these bottom-line benefits must be balanced against the tolerance of the customer for the potential operational costs of access problems with providers and increased hassle factors in filling prescriptions.

In the undifferentiated PBM market, the introduction of disease management (DM) programs should improve the overall quality of the health care delivered. In this regard, DM programs are a TQM measure. Some offerings are directed toward decreasing drug costs or shifting therapeutics from one treatment to another. These offerings should be evaluated by the benefits of such interventions in decreasing the overall health care costs, and not the value of cost shifting within the pharmacy benefit carve out.

CONCLUSION

Managing the pharmacy benefit is every bit as challenging as managing any other expense in the budget. Companies need to commit to the doctrine that health care, and especially medication therapy, must be proactively managed and not outsourced without appropriate oversight.

The pharmacy benefit is complex and is driven by providers with many different and oftentimes conflicting incentives. Managing this benefit requires professional assistance to separate the appealing benefits on the surface with the actual benefits and risks incumbent in the system.

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Geographic Names: US

Descriptors: Pharmacy benefit management; Managed care; Total quality; Prescription drugs

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Business & Technology Editors

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Revolutionizes Traditional Licensing Process for Libraries and Academic Institutions; IUPUI Implementation Dramatically Reduces Delays, Workloads and Administrative Costs

RoweCom Inc. (Nasdaq: ROWE), the leading B2B provider of e-commerce solutions for managing the acquisition of knowledge resources for the academic, medical, business, and government communities, today announced the industry's first electronic journal licensing service for libraries and academic institutions.

The service, currently in use at Indiana University Purdue University Indianapolis (IUPUI), transforms the traditional client-publisher relationship by allowing RoweCom's Faxon Academic & Medical Services to proactively manage e-journal license negotiations with publishers on its clients' behalf, thereby providing timely access to critical e-journal content in a variety of disciplines.

The explosive growth of e-journals in recent years has made it increasingly important for libraries and academic institutions such as IUPUI to access current electronic journal content as quickly as possible. In order to accomplish this, libraries and academic institutions were required to negotiate individual license agreements directly with publishers on a case-by-case basis, a labor-intensive and burdensome administrative process that stretched resources and led to long delays in gaining access to critical information. RoweCom's e-journal licensing service manages the entire electronic journal acquisition process, including all registration, licensing, invoicing, and legal review tasks, reducing the associated workload and costs, and enabling faster and more reliable access to critical medical, scientific, technical, and other content.

"What makes RoweCom's e-journal licensing service so unique is its ability to provide the same level of access to key e-journal content and fundamental efficiency that we have traditionally enjoyed with print subscriptions," said David Lewis, deputy university librarian, IUPUI. "This service has significantly reduced the administrative burden we have been facing, allowing us to free up vital resources to concentrate on our core areas of focus."

"RoweCom has broken new ground by providing the industry's first e-journal acquisition solution, addressing a key problem faced by libraries and academic institutions in today's environment - access to information," said David Fritsch, director, library strategic initiatives for Faxon, RoweCom Academic and Medical Services. "This streamlined and efficient service has allowed us to extend the value of our traditional print subscriptions acquisition process to the e-journal arena, enabling libraries and academic institutions to realize significant cost and time efficiencies, and maintain access to key content."

About IUPUI University Library

The University Library of Indiana University Purdue University Indianapolis serves as an academic research centerpiece for the campus and the citizens of Indiana. Opened in 1993, the current University Library facility hosts an integration of traditional and contemporary print and electronic resources serving between 25,000-30,000 undergraduate and graduate students from the Indiana University Schools of Business, Education, Journalism, Liberal Arts, Library & Information Science, Music, Nursing, Public & Environmental Affairs, Social Work, Physical Education, the Herron School of Art and the Purdue University Schools of

Science and Engineering & Technology. Throughout the brief history of IUPUI, the University Library has become globally recognized as a model for advanced academic library information and technology programs and services. For more information about the IUPUI University Library, call (317) 274-8278, or visit www.ulib.iupui.edu.

About RoweCom

A first mover in business-to-business e-commerce, RoweCom Inc. develops and operates Web-based services that enable organizations to manage the acquisition of knowledge resources such as magazines, newspapers, journals and books. RoweCom's flagship services, Knowledge Store (kStore) and Knowledge Library (kLibrary), allow organizations to order, pay for and manage over 200,000 titles online as well as millions of discounted books via RoweCom partner barnesandnoble.com. With clients ranging from Fortune 1000 companies to academic libraries, RoweCom serves organizations with intensive knowledge requirements and high-volume purchases. Faxon, a long-established leader in academic information services, joined RoweCom in October 1999, allowing the combined company to offer expanded Internet and e-commerce tools as well as new levels of control, convenience, and cost-savings to their clients. Faxon, RoweCom Academic and Medical Services, continues its role as an industry leader providing traditional print and e-journal services; budgeting and collection development solutions; high-quality personal service; and cutting-edge web-based services including Subscription Depot, License Depot, and Information Quest (IQ). The publicly held company (Nasdaq: ROWE) is headquartered in Westwood, Mass. and has offices in North America, Europe and Australia. Visit the RoweCom Website at www.rowe.com.

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